STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #80657.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. Based on record review and interview the facility failed to give 2 (#54, #58) residents notice prior to receiving new roommates. Finding included: - The room changes sheet provided by the facility revealed resident #54 received a new roommate on 10/13/13, 12/31/13, 2/19/14, and 8/8/14. Review of the clinical record for resident #54 lacked evidence of notice prior to receiving new roommates. Interview on 12/2/14 at 5:24 P.M. with the resident revealed he/she denied that staff gave him/her notice prior to receiving new roommates. Interview on 12/4/14 at approximately 10:00 A.M. with administrative nursing staff M revealed it was the responsibility of the social worker to complete a progress note to document that the resident	F 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 1	F 247		

was notified prior to receiving new roommates. Staff M acknowledged the clinical record lacked evidence of this notice. Staff M reported he/she expected a progress note to be completed when a resident was notified of receiving a new roommate.

Interview on 12/4/14 at 11:03 A.M. with licensed nursing staff K revealed he/she expected residents to be given notice prior to getting a new roommate.

Interview on 12/4/14 at 3:36 P.M. with administrative nursing staff B revealed the social worker talked with resident prior to them receiving a new roommate. Staff B stated he/she expected the clinical record to contain documentation showing the resident was given notice.

The policy provided by the facility with a revision date of October 2009 regarding resident rights revealed the social worker was responsible to introduce new roommates and give verbal notice to the resident and legal representative, and document it in the medical record.

The facility failed to give notice prior to receiving a roommate.

- The room changes sheet provided by the facility revealed resident #58 received a new roommate on 10/4/13 and 8/15/14.

Review of the clinical record for resident #58 lacked evidence of notice prior to receiving a new roommate.

Interview on 12/3/14 at 7:21 A.M. with the resident revealed he/she denied that staff gave

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 2 him/her notice prior to receiving new roommates. Interview on 12/4/14 at approximately 10:00 A.M. with administrative nursing staff M revealed it was the responsibility of the social worker to complete a progress note to document that the resident was notified prior to receiving new roommates. Staff M acknowledged the clinical record lacked evidence of this notice. Staff M reported he/she expected a progress note to be completed when a resident was notified of receiving a new roommate. Interview on 12/4/14 at 11:03 A.M. with licensed nursing staff K revealed he/she expected residents to be given notice prior to getting a new roommate. Interview on 12/4/14 at 3:36 P.M. with administrative nursing staff B revealed the social worker talked with resident prior to them receiving a new roommate. Staff B stated he/she expected the clinical record to contain documentation showing the resident was given notice. The policy provided by the facility with a revision date of October 2009 regarding resident rights revealed the social worker was responsible to introduce new roommates and give verbal notice to the resident and legal representative, and document it in the medical record. The facility failed to give notice to this resident prior to receiving a roommate.	F 247		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3	F 253		

maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. Based on observation, record review, and interview, the facility failed to provide a sanitary environment for the staff and residents.

- Observation on 12/02/14 at 9:03 A.M. in the 200 hall clean utility room revealed a black substance covered the wall of the bottom row cabinet spaces. The black substance was present on 1 base board in a cabinet that was broken and contained 6 one gallon bottles of drinking water.

Interview on 12/4/14 at 1:41 P.M. with maintenance staff C stated he/she was unaware of the black substance under the lower cabinet in the clean utility room. He/she reported the black substance was a concern do to the amount of black substance present and because the flooring was falling apart.

Observation on 12/4/14 at 1:30 P.M. revealed the female spa room had black substance in a hole in the shower floor. In several different residents rooms observation revealed a green liquid on a ceiling pipe in one room, 8 rooms had scratches in paint on bathroom and bedroom walls, stained brown substance to privacy room curtains, toilet bolts missing, rust on pipes, and one room with grime build up around sinks. Observation revealed 2 rooms with the sink pulling away from the wall in a resident ' s room and a sink with cardboard and scotch tape placed around the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 pipe to cover the wall. Interview on 12/4/14 at 1:30 P.M. with maintenance staff C stated the facility was aware of the black substance and sprayed the black substance weekly. The pipes and repainting the rooms and bathrooms would be worked on. During the painting process sinks would be removed and replaced, and that sometimes residents sit on the sinks. The toilet bolts were missing due to residents removing them and hiding them. The cardboard around the sink pipe would be removed and putty would be placed around the pipe. The facility failed to provide a sanitary environment for several resident rooms, the female spa room, and the clean utility room.	F 253		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to prevent multiple injury falls for 1 (#22) of 4 residents reviewed for accidental hazards.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

Findings included:

- The 10/12/14 significant change Minimum Data Set (MDS) for resident #22 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment but he/she did display potential indicators of psychosis (any major mental disorder characterized by a gross impairment in reality testing) as evidence by hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The resident required extensive assistance from 2 or more staff members for bed mobility, transfer, walking in his/her room and the corridor, locomotion on and off the unit, dressing, and toilet use. He/she was not steady and was only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around while walking, moving on and off the toilet, and surface-to-surface transfers. The resident used a wheelchair or walker for ambulation and had range of motion impairment for one upper extremity and one lower extremity. He/she had a fall within one month of admission, had a fall within 2 to 6 months of admission, and had a fracture related to a fall within 6 months of admission.

The 10/12/14 Care Area Assessment (CAA) regarding communication revealed the resident had mental illness, cognitive impairment, and delusions affecting his/her communication and thought process thus he/she got off topic and verbalized delusional thoughts.

The 10/12/14 CAA regarding activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

living (ADLs) revealed the resident had a long history of cyclic mental illness with ongoing cognitive and communication impairment with hallucinations and delusions. He/she received therapy services through physical therapy and occupational therapy and used a wheelchair for safety during therapy.

The 10/12/14 CAA regarding falls revealed he/she had several falls prior to a recent hospitalization. One of the falls resulted in a hip fracture and another fall resulted in fractures of fingers on his/her left hand.

The fall risk assessment dated 7/15/14 revealed a score of 11 (score of 10 or higher indicated the resident was a t risk for falls). On 10/5/14 he/she scored 17 for fall risk and on 11/20/14 he/she scored 22 for fall risk.

The care plan with a revision date of 12/3/14 revealed the resident had impaired self-care and required staff support to complete ADLs related to a long history of mental illness with impaired thought, impaired cognition, pain and a hip fracture. When the resident became over stimulated or delusional he/she sometimes had difficulty expressing his/her needs and wants. He/she continued to be delusional regarding his/her pain and was not consistent as to what hurt or where it hurt. The care plan also revealed the resident had a history of being reluctant to ask for help. Staff observed for medication side effects, assisted to keep his/her environment well lit and free of clutter, kept his/her bed in a low position, provided nonskid footwear, reminded the resident to not transfer independently, and encouraged him/her to use his/her call light when he/she needed assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

The nurse's note (NN) dated 10/31/14 at 3:04 P.M. revealed the resident sustained a fall in the dining room. He/she stood from the chair he/she was sitting in, reached for his/her walker and fell onto his/her left side. During the fall the resident hit the right side of his/her head on the arm of the chair and then hit the left side of his/her head on the floor resulting in 3 centimeter lacerations on both sides of his/her head. Staff applied steri-strips to the lacerations and initiated neurological checks.

The fall investigations provided by the facility revealed a fall on 10/31/14 with casual factors included a history of falls, shuffling and unsteady gait at times, psychotropic medication use, diagnosis of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and recent antibiotic use. Recommendations and new interventions placed by staff included resident education on proper technique to get out of a chair, resident education on proper positioning of his/her walker when sitting in a chair, and request of the resident to ask for staff assistance when he/she needed help with ambulation.

The NN dated 1/5/14 at 10:23 A.M. revealed the resident sustained an unwitnessed fall at 6:45 A.M. in his/her room that day resulting in 2 skin tears to his/her right forearm. The resident reported to staff he/she started leaning over and just fell.

The fall investigation provided by the facility revealed a fall on 1/5/14 with causal factors including the resident was to use his/her walker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

for ambulation due to an unsteady gait, the resident had a shuffling gait, he/she had chronic mental illness with impaired decision making and impaired judgment. Recommendations and interventions placed by the staff included resident education on use of the call light for assistance when he/she was unsteady and to use his/her walker at all times.

The NN dated 6/20/14 at 8:55 P.M. revealed the resident sustained a non-injury fall. Staff witnessed another resident attempting to assist this resident with transfer from a recliner resulting in the resident falling to the floor onto his/her right side.

The fall investigation provided by the facility revealed a fall on 6/20/14 with causal factors including staff observation of another resident assisting him/her, the resident's balance and gait were unsteady, and he/she had a long history of chronic mental illness with impaired decision making and judgment. Recommendations and interventions placed by staff included resident education to not ask other residents for assistance.

The NN dated 7/7/14 at 12:55 P.M. revealed the resident sustained an unwitnessed injury fall. Staff heard the resident yell from the hallway outside the resident's room. Staff found the resident laying with his/her torso supine on the floor just inside the doorway to his/her room with his/her left arm along his/her side and his/her right arm above his/her head. The resident's legs were extended with knees slightly bent and "somewhat pointing to his/her right side." He/she responded to staff voice but answers were not appropriate. Assessment showed his/her pulse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

was rapid and thready but the pulse oximeter revealed a pulse of 92 beats per minute. The resident moaned, "ouch" upon palpation of his/her left rib/axilla area. He/she also moaned in response to touch on his/her left hand and visual displacement between his/her second and third knuckle was noted. He/she was lethargic. The resident was transported via ambulance to the hospital for evaluation.

The NN dated 7/8/14 at 8:49 A.M. revealed x-ray results from the hospital indicated fractured ribs and fractured fingers.

The fall investigation provided by the facility revealed a fall on 7/7/14 which was reported to the state and resulted in multiple fractures, 3 fingers on his/her left hand and 2 ribs on his/her upper ride side. Review showed the resident was attempting to ambulate to the bathroom without staff assistance. Causal factors included the resident had been recently readmitted from the hospital and had a weakened condition. Recommendations and interventions placed by staff included resident education on importance in asking for assistance when ambulating.

The NN dated 7/8/14 at 2:09 P.M. revealed the resident sustained an unwitnessed fall while ambulating to the bathroom independently. He/she showed some limitation in range of motion for his/her lower extremities and was transported to the hospital to rule out a hip fracture.

The NN dated 7/8/14 at 7:30 P.M. revealed the resident returned to the facility with no new orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

The fall investigation provided by the facility revealed a fall on 7/8/14 with causal factors including a weakened condition related to illness, a previous fall with rib and finger fractures, and a history of chronic mental illness with impaired judgment and decision making. Recommendation and interventions placed by staff included the resident was transported to the hospital for evaluation and x-ray of his/her hip.

The NN dated 7/23/14 at 11:19 A.M. revealed the resident sustained a non-injury fall in which he/she was lowered to the ground by staff. He/she was transported to the hospital for evaluation.

The NN dated 7/23/14 at 6:00 P.M. revealed the resident returned to the facility with no new orders and no new injuries noted.

The fall investigation provided by the facility revealed a fall on 7/23/14 with causal factors including he/she was in a weakened state and working with physical therapy (PT), was evaluated by PT on 7/22/14, he/she returned from the hospital on 7/5/14 and was in the process of gaining strength back to baseline, and had chronic mental illness with impaired judgment and decision making. Recommendations and interventions placed by staff included staff assessment of the resident and transportation to the emergency room for evaluation.

The NN dated 9/27/14 at 11:57 P.M. revealed the resident sustained an injury fall. The fall was observed by a certified nurse aid (CNA) but he/she was unable to get to the resident fast enough to prevent the fall. The CNA observed the resident hit the left side of his/her head and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

he/she lay on his/her back and complained of left hip pain. Staff noted the left side of the resident's face was swollen and he/she refused to extend his/her legs. Staff transferred the resident to the hospital for evaluation.

The NN dated 9/28/14 at 9:25 A.M. revealed the resident was admitted to the hospital for the diagnosis of a hairline fracture of the left hip.

The NN dated 9/28/14 at 10:31 A.M. revealed the resident's guardian called the facility to notify them the resident was in surgery to have 2 pins placed in his/her hip.

The NN dated 10/5/14 at 3:01 P.M. revealed the resident returned to the facility.

The fall investigation provided by the facility revealed a fall on 9/27/14 was reported to the state. The reports showed he/she typically ambulated with a front wheeled walker, had a steady, shuffling gait and his/her care plan showed he/she was reluctant to ask for help, was to ask for assistance if needed, and staff encouraged him to perform independent tasks with minimal staff assistance. Casual factors included a long history of mental illness with impaired judgment and decision making ability, a BIMS score 12 (indicating moderate cognitive impairment), and a history of falls. Recommendations and interventions placed by staff included staff kept the resident comfortable until the ambulance was able to arrive after the fall, he/she was transported to the emergency room for evaluation, and he/she was later admitted to the hospital for a hairline fracture of the left hip.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

Observation on 12/3/14 at 2:22 P.M. revealed therapy staff H and direct care staff F assisted the resident to transfer from his/her wheelchair to his/her bed using a physical assistance, verbal cues, and a gait belt. The resident was able to follow verbal cues from staff and moderately participate physically in the transfer.

Interview on 12/2/14 at 11:20 A.M. with the resident revealed he/she replied to the question, " how long have you lived here?, " with, " 1 teaspoon. " He/she also responded to the question, " What is the food like here?, " with, " 3/4 cup. " The resident was determined to be non-interviewable.

Interview on 12/3/14 at 2:42 P.M. with direct care staff F revealed the resident was considered a fall risk but now that he/she was in a wheelchair he/she was no longer really a fall risk. Staff F reported he/she sometimes looked at the care plan but mainly found out about interventions through report from other staff members.

Interview on 12/4/14 at 10:13 A.M. with direct care staff I revealed prior to the resident's injury falls staff tried to educate him/her on proper walking techniques and proper use of his/her walker. Direct care staff I reported he/she learned that information through staff report but believed it was also on the care plan.

Interview on 12/4/14 at 11:03 A.M. with licensed nursing staff K revealed the staff provided a 1 or 2 person assist with transfers depending on the resident's willingness to participate in ADLs. Staff K reported prior to the hip fracture staff encouraged him/her to use the call light, kept his/her bed in a low position, and educated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

him/her on asking staff for assistance. Staff K felt the resident was able to remember to use his/her call light when staff reminded him/her. Staff K reported post fall staff reviewed the investigation and looked into new interventions to prevent future falls and updated the care plan accordingly.

Interview on 12/14/14 at 2:17 P.M. with direct care staff J revealed he/she was not sure if the resident was a fall risk but he/she thought so. Staff J reported staff provided 2 person assist with a gait belt for transfers, ensured he/she wore nonskid footwear, and kept the bed in a low position.

Interview on 12/4/14 at 2:52 P.M. with licensed nursing staff L revealed staff encouraged the resident to call for assistance. Staff L stated the resident was able to remember to use the call light "to a degree," and that was why staff frequently reminded him/her to do so.

Interview on 12/4/14 at 3:18 P.M. with administrative nursing staff M revealed when a fall with injury occurred the charge nurse was responsible for initiating an immediate intervention based on the circumstances of that fall. Staff M reported when this resident had the fall with fractured fingers and ribs he/she was already receiving therapy to try to balance and strengthening, staff was using gait belts with transfers. He/she reported after that fall one of the biggest things staff did to reduce his/her risk for falls was to increase the use of his/her wheelchair due to his/her fractures fingers making it difficult to use a walker and initiate 2 person assist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175455	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ESKRIDGE	505 N. MAIN ST. ESKRIDGE, KS 66423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

Interview on 12/4/14 at 3:36 P.M. with administrative nursing staff B revealed the facility began to attempt to identify a resident at risk for falls immediately upon admission based on old records and the nurse's admission assessment. Those findings alerted the nurse to get a plan in place for fall prevention. If a resident was a new fall risk then the staff implemented an IPOC (immediate plan of care) to be able to get into the chart quickly so all staff would be aware. The IPOC was kept in the chart until staff completed the comprehensive care plan. Staff B reported this resident had an intermittent unsteady gait. He/she stated fall alarms were not successful at the facility due to the type of community (mental health) and tended to make the residents more anxious. For this resident staff implemented use of a wheelchair, a walker, toilet riser, kept the bed in a low position, and placed a mobility bar on the bed to assist with transfers. Staff also kept the resident in a room that was directly across the hall from the administrator's office so close supervision could be provided. Staff B acknowledged that at times the resident was not cognitively able to remember to use the call light due to mental illness. Staff B stated that at times the resident understood staff instructions and other times did not. He/she stated when the resident appeared to staff to be less coherent then they knew he/she needed more supervision so the staff monitored the resident more closely. Staff B reported the facility had a " stop and watch " program when a staff member noted a difference in a resident they would document it on that piece of paper.

The policy provided by the facility with a reviewed date of 6/12/14 regarding fall management revealed the facility implemented a fall prevention

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F 323	Continued From page 15 and intervention program. The facility failed to develop and implement appropriate interventions to prevent multiple injury falls for this resident with known long history of mental illness with impaired cognitive skills and judgment.	F 323		